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ABSTRACT

Five papers cover various aspects of the Macomb (Illinois) 0-3 Regional Project, a home based program for rural handicapped and high risk infants and toddlers. The first examines ways to develop public awareness of the importance of early intervention through media and contact with medical, school, and community professionals. The second paper describes a referral system and network, while the third discusses ways to work closely with physicians, nurses, and hospital personnel. (Sample forms are appended.) The establishment of an advisory council is considered in the fourth paper, while placement of children at the conclusion of the infant program is addressed in the final paper. (CL)

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Macomb 0-3 Regional Project
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BABY BUGGY PAPER NO. 172

Development of General Awareness of the Importance of Early Intervention

by

Nancy McKee

June, 1978

EC122414

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USOE-BEH Grant No. G00-7[illegible]0234 Project No. 44 AH 50417

One of the first steps in implementing a program of service delivery to handicapped and/or delayed infants is the development of general awareness on the part of the public as to the importance of early intervention in the lives of these young children and their families. Information as to why it is important to intervene with young children at the earliest possible moment of their young lives, the types of services available to these families enrolled in a infant project, and the capabilities of the staff to deliver these services must be spread by every possible means of communication. Not only does such widespread dissemination effort result in an increase of knowledge and understanding in a given community, but it also helps to lay the groundwork for an effective community referral system for an infant project. Staff members of the Macomb 0-3 Regional Project, a home-based federally funded demonstration project whose objective is the education/remediation of handicapped, high risk, and/or developmentally delayed young children, ages zero to three, and their families who reside in a rural area, discovered the necessity of undertaking a general awareness campaign in the 3-county rural target area of west-central Illinois early in the first year of its operation.

General awareness can be geared to a variety of target audiences: the public at large, professionals in the field of medicine, members of human service agencies, school personnel, day care and nursery school personnel, service and church organizations, and citizens of the community. Although procedures for stimulating general awareness may vary somewhat depending upon the target audience, there is overlapping in the techniques employed. The following procedures are those which have been implemented most effectively by the Macomb 0-3 Project in a 3-county rural area.

Target Audience	Procedures
Public at large	- Media - newspapers, radio and t.v. interviews - Brochures - doctors' offices, hospitals - Brochures to new mothers at hospitals - Posters - laundromats, drugstores, other public places - Participation in community events (Homecoming parade, sidewalk sale display) - Personal contacts - General information newsletters
Medical professionals	- Personal contacts - physicians, hospital administrators, nurses, P.T. and O.T.'s - Presentation of slide/tape overview of Project - Invitations to membership on Advisory Council - General information newsletters

Target Audience	Procedures
Human service agencies (Public Health, Dept. of Child and Family Services, mental health agencies, et cetera)	- Membership and participation in local Interagency Councils - Personal contacts - Presentation of slide/tape overview of Project - Invitations to workshops and in-services sponsored by Project - Newsletters - Membership and participation on boards
School personnel	- Personal contacts - administrators, psychologists, preschool handicapped teachers - Presentation of Project slide/tape - General information newsletters - Attendance at preschool screenings - Invitations to workshops and in-services sponsored by the Project - Invitations to membership on Advisory Council - Communications and cooperation re caseload in terms of staffings as child nears three years of age
Day care and nursery school personnel	- Personal contacts - Presentation of Project slide/tape - Brochures - Invitations to workshops and in-services sponsored by the Project - Newsletters
Service and community organizations	- Personal contacts - Presentation of Project slide/tape - Brochures and reprints of news articles - Newsletters - Membership in local UCP, ARC, United Way

The above list of procedures undertaken by the Macomb 0-3 Project staff are suggestions for individuals desiring to undertake a general awareness campaign in their target area. These procedures undoubtedly will vary from project to project, depending upon geographical location, nature of the population, coordination of helping services, and number of project staff available. The goal of arousing general awareness of the importance of early intervention remains of paramount importance throughout the months and years of any infant project dealing with handicapped and delayed young children.

Macomb 0-3 Regional Project
June, 1978

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June, 1978

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USOE-BEH Grant No. G00-75-00234 Project No. 44 AH 50417

Development of a referral system in a parent/infant project delivering services to handicapped, high risk, and/or delayed children in a rural area is vital to the success of the entire project. As experienced by staff members of the Macomb 0-3 Regional Project, the task involves two major steps: development of a referral network and development of a referral process. Baby Buggy Paper No. 171 describes some of the procedures involved in the evolution of a referral system.

Referral Network

The process of disseminating general awareness of the importance of early intervention and the work of infant projects is an on-going one. While general public awareness is being aroused thorugh posters, brochures, newspaper articles, and radio and t.v. interviews, face-to-face contacts are being made with individuals in community organizations and agencies. Personal relationships established early remain effective throughout an entire program. By maintaining a cooperative posture with local helping agencies and professional personnel, a referral network begins to emerge. It is advisable to use periodic visits to physicians, hospitals, and helping agencies, offering Project help whenever possible in the way of consultation, in-service training, and use of their staff members to coordinate services to children in every way possible. Participation of Project staff in interagency councils, local associations working with handicapped individuals, and day care boards manifests interest and enthusiasm, as well as making valuable contacts for future referrals of children.

After the initial referral network of cooperating local agencies has been established and is beginning to work fairly smoothly, cooperative services among members of the network should be encouraged. Consultants are always needed in an infant project, whether it be for a speech or vision problem, emotional upset, physical therapy prescriptions, services of Crippled Children's Clinic, or any of the many presenting problems of young handicapped or delayed children and their families. Frequent communication is important and should be maintained between consultants and Project staff concerning suggestions for activities for an individual child, report on a child's progress or lack of progress, change of address of the family, and other relevant concerns. In turn, the Project can often be of service to these same consulting agencies by sponsoring in-services and workshops to upgrade professional skills.

Examples of specific cooperative services engaged in by staff of the Macomb 0-3 Regional Project with local agencies are as follows:

a. Practicum site for speech pathology graduate students
b. Use of Western Illinois University Speech and Hearing Clinic for speech and audiological evaluations of Project children and as a mutual referral source

c. Training of staff at Department of Child and Family Services, McDonough and Hancock Counties, and cooperation with Homemakers relative to Project families
d. Exchange of information with area 0-3 projects
e. Active membership in Interagency Councils of McDonough and Hancock Counties - exchange of information, source of referrals
f. Cooperation with LEA - notification of on-going caseload (by location, age, and handicapping condition unless permission is obtained from parents), staffings for children turning three
g. Contract with the McDonough County Rehabilitation Center workshop for wooden blocks to be used by Project children
h. On-going contacts with area physicians, including correspondence, in-service on the work done by infant projects, involvement with the Project Advisory Council, and use of physicians' staff for consultation

Once general awareness has been aroused and the beginnings of a cooperative network for referrals from the community has been established, referrals should begin coming in to the Project office. When a referral is received, it must be processed as soon as possible (within a one or two week period.) A follow-up report to the person(s) making the referral lets the referral source know that contact has been made with the family and the decision has been made by parent(s) and staff as to whether enrollment in the Project is appropriate and desirable. It is important that an efficient referral system be developed to insure accurate processing of information.

Referral Process

Referrals are made in a variety of ways. Most commonly, they are received by means of a telephone call to the office. Some referrals, however, are made in face-to-face contact at social agency meetings and in-services, with parents during home visits, and in a variety of other situations. No matter how the referral originates, it is necessary for the staff member to get as much pertinent information about the child that the source can give and to record it systematically. When taking a referral, the staff member records the child's name, age, birthdate, and phone number (if known), parents' names, reason for referral, address, and directions to the home where necessary.

A caseload file box is a good means of recording referrals. A 4 x 6 recipe size card is used for each individual. A sample referral card used by the Macomb 0-3 Project follows.

Child # _____

Name _____ Entry Date _____

Birthdate _____ Reason for Service _____

_____

Address _____ County _____

_____

Parents' Name _____ Phone _____

Referral Source _____

The caseload box is divided into the following subdivisions:

a. Present caseload
b. Children no longer being serviced
c. Children evaluated - not serviced
d. Other children
e. Referrals (pending)

After a referral is received, the child is assigned a number. A master listing of child's name and number is kept to avoid duplication of numbers. The purpose of assigning numbers is to identify children by code numbers rather than by names to insure confidentiality. The information taken and the number are then transferred onto a referral card and placed into the referral section of the caseload file box.

Prompt action in response to a referral is very important. If a referral is neglected for several weeks, the project is apt to lose credibility in the eyes of the referral source. Lack of follow-up on referrals is a cardinal sin in infant projects. Busy staff members somehow must manage to contact new referrals within one to two weeks, if at all possible.

After the referral has been contacted, the staff member completes any further information on the card that is needed. If the family signs the required forms to enter the Project, the child's card is placed in section A, "Present Caseload." It will remain in this section as long as the child is in the Project.

At this time, the Child Development Specialist (CDS) also prepared two folders for the child. One is a confidential folder to be kept in a locked file cabinet. It will contain all of the signed Project forms, formal assessment forms, medical information, carbon copies of correspondence concerning the child, evaluation reports (O.T., speech and hearing, etc.), bi-yearly goals, differential needs, and child summary. The second folder is a working file to be maintained by the CDS. It will contain activity plans for the child, a copy of bi-yearly goals and O.T. reports, and any other information relevant to on-going delivery of service to the child.

When a child turns three or is terminated for any reason, the card is then placed in section B, "Children No Longer Being Serviced." In the case of children who are evaluated but not serviced for one reason or another, the referral card is placed in section C, "Children Evaluated--Not Serviced." A referral that is contacted but not evaluated or serviced is placed in section D, "Other Children."

By using this method, staff members are able to maintain an accurate and efficient record of the number of children served and the total number of referrals contacted. The caseload file box is accessible for all to use in record-keeping. Whatever system is employed, an efficient referral system is essential in maintaining an effective delivery of services in an infant project.

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Macomb 0-3 Regional Project
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27 Horrabin Hall
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BABY BUG

Maintaining Communication an Medical Community

Patricia Hutinger, U

June, 1978

Project Director: Patricia L. Hutinger, Ed.D.

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Phone: 309-298-1634 or 309-298-1072
USOE-BEH Grant No. G00-75-00234 Project No. 44 AH 50417

When a project works closely with handicapped or high risk children of any age and their parents, it is necessary to maintain communication with members of the medical profession. The purpose of the present paper is to outline some of the procedures used by the Macomb 0-3 Regional Project in developing a referral and information network with physicians, nurses, and hospital personnel.

The Macomb 0-3 Regional Project planned to elicit cooperation from the medical community from the onset of the Project. The following guidelines were developed:

1. Make personal contacts in disseminating information about the Project.
2. Develop a clear, concise description of the Project.
3. Leave printed materials after personal contact has been made.
4. Establish priorities for impact.
5. Obtain membership of a physician on the advisory council.
6. Organize meetings at hospitals.
7. Send letters, forms, and permission slips to request medical information about children. Follow up compliance with thank you letter.

It is imperative that an infant program for high risk and handicapped infants and toddlers develop and maintain a positive two-way relationship with physicians and other members of the medical community. Since many parents take their child to a physical when they would not take the child anywhere else, the physician may be the single person who has knowledge of the child's problems. The physician, therefore, is frequently an excellent source of referrals and also a provider of important information about specific children. Since physicians customarily hold respected positions in most communities, their support for an infant project usually helps gain public approval for the project. As many children's problems stem from a medical source, it is doubly important for an infant project to work closely with the medical community in order to provide the best possible experiences for the children.

Personal contacts with physicians should be made at the beginning of the Project. Letters and/or brochures may never actually reach the physician. When printed materials do reach him/her, questions that may arise usually go unanswered. Seldom do the printed materials explain the Project fully, nor does the doctor have time to spend calling the Project for further information. There is really no substitute for personal contacts, time-consuming though they may be.

In the Macomb 0-3 Project, before the contacts were initiated, a clear, concise description of the Project's major components was developed in the form of a brochure. The individual making the contact delivered as much information as possible in a very short time, leaving brochures for the physicians to read as

well as to give to interested patients. (These brochures are frequently found in waiting rooms and in examination rooms.) After the initial face-to-face contact, the printed materials served to reinforce the information presented during the first contact. Development of a slide/tape overview of the Project delivery of service components followed at the end of the first or planning year, and proved to be a valuable dissemination tool in reaching individual physicians as well as large groups of medical professionals.

Upon consideration of the make-up of the medical community in the rural areas served in a three-county area of west-central Illinois, the Macomb Project staff decided to contact obstetricians, pediatricians, and general practitioners first. Specialists were then also contacted. In meetings at area hospitals, however, a wide variety of physicians were usually contacted, so established priorities for impact were not always maintained. (Priority in making contacts is perhaps a greater concern in larger, urban communities.) Project staff used every opportunity available to make contacts with the medical community, including unplanned informal contacts of a social nature.

Through contacts with Project children, parents, and staff, a local pediatrician became very interested in the Project. When a parent invited him to join the advisory council, he accepted. This pediatrician has been extremely helpful in providing access to other physicians. He was instrumental in arranging the first luncheon meeting for the Project attended by other physicians at the local hospital. At this meeting, Project staff presented the general slide/tape, provided printed materials, answered questions, and presented information. In addition, the Project paid for the luncheon! The Project presentation is non-threatening to the medical community--the staff are not interested in entering the medical field, but rather in supplementing, aiding, and following the development of children who need special help. This orientation is maintained in all Project materials and activities.

Response to the luncheon presentation was positive, resulting in more referrals to the Project. One physician, after praising the general concept of the Project, voiced the opinion that such a project should be available for all parents, not just those whose children were at risk or handicapped. Generally expressed comments were favorable regarding the helping nature of the Project and the support it provided for parents. Several physicians offered to help in making appeals for continuation monies, if necessary.

Contacts with the medical community included not only physicians, but also nurses, hospital administrators, and obstetrical and pediatric nurses as well. It was through a face-to-face meeting with a hospital administrator in Keokuk, Iowa, that the Project staff located an outstanding occupational therapist who provided consulting, hands-on service two days each month during the third

year of the Project. (Few rural communities have the luxury of having available the services of an occupational therapist or a physical therapist.) As a result of face-to-face contacts with area hospital administrators, these hospitals agreed to carry a special brochure about the Project which was especially designed for new mothers. The brochure is presented to each new mother who delivers a baby in the hospital. Five area hospitals in a three-county area used the brochures regularly, calling the Project office when their supply ran low. Gaining such hospital approval was accomplished in a time period of eight months.

The pediatrician who is a member of the Project advisory council also offered the Project the services of his pediatric nurse. Referral and follow-up information on Project children was easily obtained through the office nurse. In addition, the pediatric nurse devoted one afternoon to guiding an in-service workshop on early identification of anomolies for Project staff and a large group of interested professionals from surrounding communities.

An additional procedure for establishing positive relationships with physicians involved requesting medical records. When a child entered the Project, his/her medical records and recommendations were requested from the physician (with parental permission). Such information helped Project staff members to avoid any errors in judgment that might harm the child physically as well as to make appropriate decisions about the child's goals. If the physician was one who had no prior contacts with the Project, the letter requesting the child's medical records contained the following items:

1. a brief explanation of the Project
2. a request for records
3. a request for specific recommendations from the physician
4. a medical release form signed by the child's parent or guardian (enclosure)

If the physician was familiar with the Project, the first item noted above was omitted. After the records were received, a follow-up letter was sent, thanking the physician for his help. Examples of the letters and release form used by the Macomb 0-3 Project are attached. After the above procedure for obtaining medical records was initiated, physicians were most cooperative in responding quickly. Communication and follow-up were maintained on a six-month basis by correspondence with physicians who initially referred a child to the Project.

The physical therapist in the district hospital in McDonough County was involved with the Project from the beginning, at first through his contact with Project children. He was invited to present an in-service to the staff during the first year of the Project. Staff members also accompanied the children to physical therapy sessions. From the start, he became one of the Project's staunch

supporters in the community, expressing a willingness to be interviewed during BEH site visits, involving parents and physicians in the Project, and providing support in various health agencies as well. The physical therapist also attended various Project in-service activities and initiated a screening system (STEPS UP) used by physician's nurses, public health nurses, and area infant project staff.

Summary

It is both wise and necessary to maintain ongoing contact with the medical community in the Project area. Medical personnel provide a ready source of advice whenever a problem arises. Ongoing contact with medical personnel is also a means of assuring that the Project is giving the best possible service to its children. Furthermore, keeping physicians informed of what the Project is doing with their particular patients reassures them that the children are receiving continual attention. For these reasons, a project will ideally request, respect, and make use of medical advice.

RELEASE OF INFORMATION

MACOMB 0-3 REGIONAL PROJECT
47 Horrabin Hall
Western Illinois University
Macomb, Illinois 61455

(1)
TO: _____

(2)
RE: _____

I hereby grant permission to disclose and deliver to:

any and all information contained in the clinical record of the above named patient. Such information disclosed or delivered may include the complete case history as shown by the records, and any other information in the possession of (3)_____ relating to this child's treatment and/or condition.

(4) SIGNATURE WITNESSED BY:

_____
(name)

_____
(address)

(5) Signed: _____

Date: _____

FOR DOCTOR'S RECORDS

NOTE: INSTRUCTIONS FOR FILLING OUT ABOVE

1. Give full name and address of doctor.
2. Give patient's full name, and birthdate.
3. Give full name of medical office, institution, etc. releasing information.
4. Give full name and address of witness.
5. Signature of parent or guardian of patient and date of signature.

WESTERN ILLINOIS UNIVERSITY
MACOMB, ILLINOIS 61455

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MACOMB 0 - 3 REGIONAL PROJECT

FORM LETTER SENT TO PHYSICIANS

Dear Dr. _____:

The Macomb 0-3 Regional Project is a federally funded program that works with handicapped, high risk, and developmentally delayed children ages zero to three years. _____ is enrolled in the Project and we would like to complete his/her medical history file.

We would appreciate your sending us any records concerning your patient, _____. A signed release of information form is enclosed.

Please feel free to contact us if you have any questions, suggestions, or recommendations. Thank you very much for your consideration.

Sincerely,

_____
Project Director
Macomb 0-3 Regional Project

USOE - BEH Grant #G00-75-00234 Project #44 AH50417

WESTERN ILLINOIS UNIVERSITY
MACOMB, ILLINOIS 61455

COLLEGE OF EDUCATION
MACOMB 0 - 3 REGIONAL PROJECT

THANK YOU LETTER FOR PHYSICIANS

Dear Dr. _____:

Thank you for your prompt response to our request for medical records on _____. We appreciate the receipt of photocopies of the information you had on file, along with the additional information sent. We are presently serving the child and his/her mother by means of weekly home visits.

Should you have any suggestions or recommendations for _____, please do not hesitate to contact us.

Sincerely,

_____
Project Director
Macomb 0-3 Regional Project

USOE - BEH Grant #G00-75-00224 Project #44-AH50417

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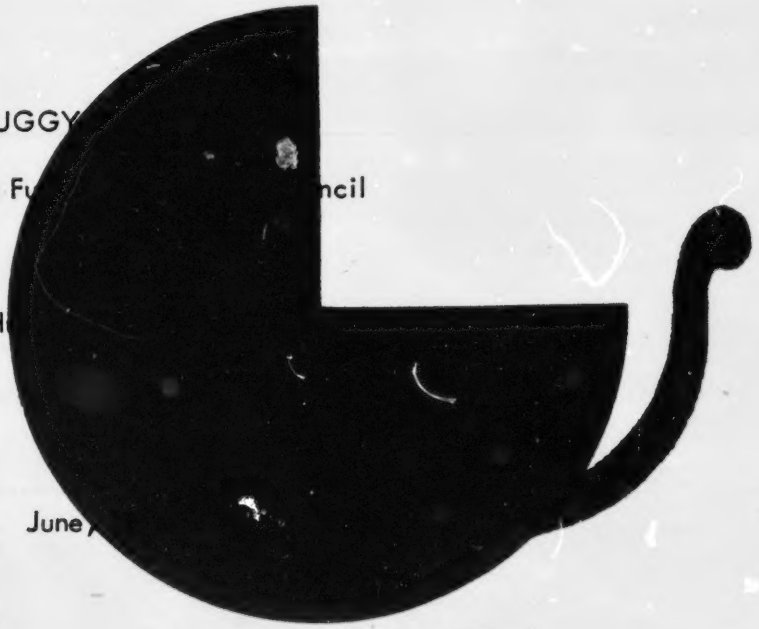

BABY BUGGY

Establishing a Fu ncil

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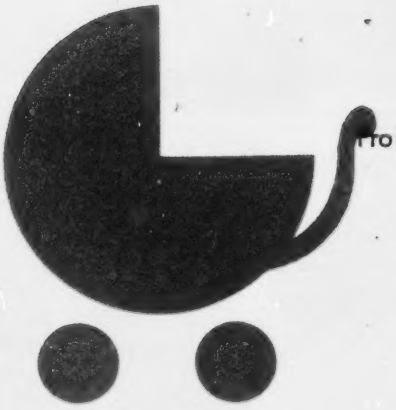
June



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Not only is an advisory council beneficial to an infant project, but in the HCEEP network of projects funded by the Bureau of Education for the Handicapped, it is essential. The proposal for funding such demonstration projects as the Macomb 0-3 Regional Project must contain the names and positions of the advisory council members, or at a minimum, the general make-up of such a council. The function of the advisory council is an ever-changing one as the project grows and develops. Ideally the council serves as a liaison between the Project and the community, the school systems, and the federal government. (Advisory council members are often sought out by members of federal site visit teams.) The council provides information to interested people, and in turn provides feedback to the Project staff regarding community activities and opinions. The council is advisory in function, rather than policy-making.

The advisory council originally formed in the Macomb 0-3 Regional Project during its first year changed substantially in the second year as the Project progressed into service delivery. During the first or planning year, since the Project was in a university setting, the chairpersons of the two departments sponsoring the grant were on the advisory council in addition to the two Project co-directors, two Special Education Cooperative directors, and one parent. Particular problems related to the operation of such a Project within the university organizational framework consumed a great deal of time and attention during the first year.

As the Project moved into the second year, services to children using the model developed for rural areas was a major focus. General awareness strategies were important, as was gaining support in various community groups. Long-term focus was placed on obtaining continuation during the Project's third year. The same objectives were carried into the third year of the Project with increased emphasis on obtaining local continuation of the model service delivery.

Selection of Members

Given the above conditions, the makeup of the advisory council changed. Members were invited to join the council through personal contact with a member of the Project staff or another council member. During the third year, the ten members of the advisory council included the following:

1. The Project director
2. The past president of the Macomb District #185 School Board who is also a veterinarian in the community
3. A special education consultant in the Illinois Office of Education
4. An administrative assistant from the Warren Achievement School in Monmouth, Illinois (a school for severely handicapped children which also has an infant service component)
5. A community member who has both nurse's training and special education experience

6. A teacher of the preschool handicapped in Hancock County
7. A pediatrician
8. Three parents of Project children

These ten members have been a strong and functional component of the Project, enthusiastic and dedicated in their support. Careful selection of members resulted in suggestions and advice based on sound knowledge of their own areas of specialty. This enabled the Project to give consideration to community needs and opinions when establishing service policies and delivery strategies. Members' advice was particularly helpful in developing successful strategies for securing local funding after the third year of the Project.

Not only is the local community an HCEEP demonstration project target, but in the case of the Macomb 0-3 Regional Project a three-county area was involved. The advisory council membership represented those areas. In addition, an effort to keep in tune with the state plan for early childhood handicapped education was constant. Influence at the national level was attempted on a small scale through an open-house attended by the advisory council members, U.S. Congressman Tom Railsback, the campaigning Lieutenant Governor candidate, and interested public. The advisory council focused on activities at all three levels.

Forming an effective advisory council is sometimes difficult and time-consuming, but ultimately it is time well spent. Parents must be recruited to serve on the council. In establishing membership, the staff needs to explore the community to find the people who are actively involved in politics, the school systems, service agencies, community projects, and the medical professions. Suggestions include clergymen, lawyers, nurses, doctors, preschool coordinators or teachers, school board members, special education personnel, public health, mental health, and other social service personnel active in the Project area. As the community is made more aware of the Project through various dissemination activities, completing the membership of the advisory council may become an easier task.

Before filling each position, it important to consider what the prospective individual can provide for the Project, the amount of time available for Project work, availability for meetings, attitudes toward the Project, and of course, willingness to serve on the council. Parents of children in the Project provide keen insight into the Project's services and family needs on a personal level.

Procedures

Advisory council meetings are held bi-monthly in the Macomb 0-3 Regional Project. An attempt is made to schedule meetings at a time convenient to the majority of the members. The meetings are held at the Project office, with special arrangements for parking on the university campus. Only one "emergency" meeting

was scheduled during the period when local continuation was sought so that members might react to a proposal affecting the Project's future.

An agenda is provided for the council members at each meeting. If time permits, agendas may be mailed before the meeting so that special preparations might be made. (Minutes of each meeting are sent, in addition to the Project Newsletter, in order to maintain frequent contact with the members during the interim between meetings.) The agenda includes a summary of Project activities (i.e., in-service training both sponsored and attended, parent workshops, consultants, cooperative activities with other agencies, and viewing of dissemination materials). The agenda also includes specific problem areas which need to be addressed. For example, when the Project was seeking local continuation, that topic appeared on the agenda at each meeting. Long discussions about the intricacies of securing continuation funds involved many hours. Other typical agenda topics include information about community needs and/or activities (sometimes board members arrange for such involvement), procedures for cooperative endeavors with other agencies, training needed for Project personnel, timing and placement of dissemination efforts, requests for presentations, and parental activities that need to be developed. When the whole advisory council attends to a major problem, methods of solving the problems tend to be diverse and the advice sound.

The advisory council members serve the Project in other ways besides attending meetings. Members provide support for the Project in the community. They talk to people about the Project, arrange for Project presentations at various organization and agency meetings, get referrals, and serve as Project representatives on community and state task forces. It was through the efforts of a council member that the Project's mobile unit was part of the Homecoming parade. Another member took the Project's proposals and materials to a state task force meeting on establishing guidelines for Early Childhood Handicapped programs.

The Council also provides feedback regarding community needs. They point out gaps in community service that might be provided by the Project. One parent suggested the establishment of a high risk infant/mother support group which ultimately became operational in the community. Finally, council members make specific contacts in their own field when needed, sometimes arranging public awareness programs, seeking Project support, and helping locate consultants needed by the Project. The pediatrician arranged for a presentation to a group of physicians, an important inroad with the medical community.

Summary

Establishing a working advisory council meant finding interested people who were willing to work to promote a rural program for handicapped and high risk infants and their parents. Since members' advice is taken seriously, they

have demonstrated a willingness to help the entire staff (and scope) of the Macomb 0-3 Regional Project. The community work done by the advisory council members has been invaluable to the successful operation and continuation of the Project.

Macomb 0-3 Regional Project
June, 1978

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27 Horrabin Hall
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What Happens

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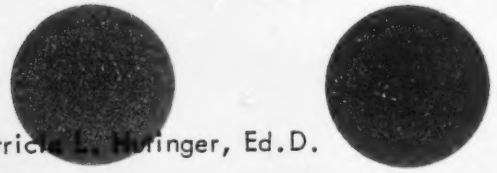

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One of the most frequent questions asked of staff members of the Macomb 0-3 Regional Project is, "What happens when a child turns three?" Many people are convinced of the importance of early intervention, but are concerned as to the long-range effects of the work done with infants if there is no follow-up after a child turns three. This paper describes the alternatives available in a rural area to parents at this important state in the life of their child.

As a child nears the age of three, the parents and CDS begin serious thinking together about the future placement of the child. The CDS's goal is to help the parent find the most appropriate educational setting.

To prepare for placement, the CDS updates the assessments on the child. Time is allocated during a home visit for a discussion with the parents as to their feelings about their child's present needs and places that might be able to meet those needs. Pros and cons of each site are considered. Often in a rural area, however, there are only one or two sites in which the child could be placed. Sometimes in the course of the home discussion, parents and CDS are not able to find a program which is apt to meet the educational needs of the child. Placement may be difficult or delayed due to a lack of facilities, waiting lists, school district boundaries, or the composition of a given classroom (a 3-year-old language impaired child in a room of 4-year-old deaf children). This informal assessment of possible placement sites may bring about a decision to keep the child in the project or at home until appropriate placement can be made. If placement is desired elsewhere, a different procedure takes place.

When the child reaches 30 months, the Regional Special Education Cooperative is notified so that district superintendents may be made aware of a need for special education services in the coming six months. If such services are deemed necessary when the child turns three, the CDS arranges for a staffing by calling the district school psychologist.* The school psychologist then sets a time and date convenient with the parent. Other interested and appropriate professionals, i.e., speech therapist, physical therapist, CDS, parents, teachers, and principal, are invited to the staffing. The CDS may recommend to the psychologist other individuals who should attend the staffing.

Parents do not always think about the total placement picture. Before the actual staffing, the CDS presents probing questions and possible problems to the parents for them to consider before placing their child. How is the child to get to school? Does the child take a nap at school? If so, will it coincide with the morning/afternoon nap that he is taking now? Is the child ready for a whole day program or would he/she work best in a half-day session? Is there a speech therapist for the child? If so, for how long and how many times a week

*Check with the administrator in the child's school district for the procedure in that area.

would the child receive therapy? Is the child able to interact with typical children? Is physical therapy available to the child? How many children are in the classroom at the present time? Can the other special needs of the child be met? One question parents often fail to ask themselves is whether or not they are prepared to let go of their child. Separation between parents and child can be a difficult adjustment for the parents as well as the child.

At the staffing, parents often feel intimidated by the "professionals" and are afraid to ask questions concerning the schools and their rights. The CDS can prepare the parents for the staffing. When possible, the parents visit the various sites in order to gain a better understanding of the environment in which the child would be placed (nursery, preschool, handicapped room, physically handicapped room).

During the staffing, the members discuss the best possible educational placement for the child as he/she turns three. This placement must be approved by the parents whether they are present at the staffing or not. After the child is placed, the CDS makes a follow-up visit or call to the family and placement center to see how the placement is working for the child.

Many children, because of early intervention or maturation or a combination of both, do not need a special educational program. For other children, the preschool handicapped classroom available to them is not suitable because of its present composition. In cases such as this, the child remains with the Project until an appropriate placement can be found. When placement of the child may be into another program, a staffing is held between the parents, CDS, and professionals.

The CDS and parent agree upon the course of action most appropriate for the child, whether it be remaining at home in the Project or attending a day care or nursery school, a special classroom, or an institution. Whatever the placement, the child's needs are top priority.